Eating Behaviors 28 (2018) 20–24

Contents lists available at ScienceDirect

Eating Behaviors

journal homepage: www.elsevier.com/locate/eatbeh

Therapists' self-reported drift from dialectical behavior therapy techniques for eating disorders

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ARTICLE INFO

Keywords:
Dialectical behavior therapy
Eating disorders
Therapist drift

ABSTRACT

Objective: Research has shown that clinicians underuse or omit techniques that constitute an essential part of evidence-based therapies. However, it is not known whether this is the case in DBT for eating disorders. The aims of this study were; 1) exploring the extent to which DBT techniques were used by self-identified DBT clinicians treating eating disorders; 2) determining whether therapists fell into distinct groups, based on their usage of DBT techniques; and 3) examining whether clinician characteristics were related to the use of such techniques.
Method: Seventy-three clinicians offering DBT for eating disorders completed an online survey about their use of specific DBT techniques. They also completed measures of personality and intolerance of uncertainty.
Results: In relation to the first aim, the pattern of use of DBT techniques showed a bimodal distribution — most were used either a lot or a little. Considering the second aim, clinicians fell into two groups according to the techniques that they delivered — one characterized by a higher use of DBT techniques and the other by a higher use of techniques that were specific to the treatment of eating disorders, rather than DBT methods. Finally, more experienced clinicians were more likely to be in the 'DBT technique-focused' group.
Discussion: DBT clinicians are encouraged to implement both sets of techniques (DBT techniques and standard techniques for the treatment of eating disorders) in an integrated way. Training, supervision and the use of manuals are recommended to decrease therapist drift in DBT.

1. Background

Cognitive behavioural therapy (CBT) is currently the most strongly evidenced treatment for adults with eating disorders, especially for binge eating disorder and bulimia nervosa (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Spielmans et al., 2013; Vocks et al., 2010), though the effects are less powerful for patients with anorexia nervosa (Dalle Grave, Calugi, Conti, Doll, & Fairburn, 2013). Family based treatment (FBT) is more effective with younger cases with a more recent onset (Lock et al., 2010). However, neither CBT nor FBT works for all patients. Therefore, developing an evidence base for other therapies has been crucial.

An alternative treatment that has achieved widespread implementation and positive outcomes for patients suffering from an eating disorder is dialectical behavior therapy (DBT) (Bankoff, Karpel, Forbes, & Pantalone, 2012; Lenz, Taylor, Fleming, & Serman, 2014). DBT is a cognitive behavioural treatment that was originally developed to treat chronically suicidal patients diagnosed with borderline personality disorder (BPD) (Linehan, 1987), and is now recognized as the leading psychological treatment for this population (National Guideline Clearinghouse, 2012).

DBT assumes that the patient has low self-regulation and tolerance to stress, and that environmental and intrapersonal factors influence such deficits (Dimeff & Linehan, 2001). The therapy combines behavioural techniques with eastern mindfulness, which is intended to replace rigid, dichotomous thinking with acceptance and validation (Dimeff & Linehan, 2001). DBT aims to improve behavioural skills and motivation, to extrapolate the acquired skills to the patient's context, and to provide an effective therapy structure for both the patient and the therapist. For this, key factors in the treatment are individual therapy, skills group training, telephone coaching, and the support of a consultation team (Dimeff & Linehan, 2001). The models of DBT for the eating disorders that are currently most commonly used are those of Safer, Telch, and Chen (2009) and Wisniewski, Bhatnager, and Warren (2009).

Research has shown that DBT is effective in treating a wide range of disorders, such as substance dependence (Linehan et al., 1999), depression (Harley, Sprich, Safren, Jacobo, & Fava, 2008), post-traumatic

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https://doi.org/10.1016/j.eatbeh.2017.12.001
Received 15 February 2017; Received in revised form 21 November 2017; Accepted 6 December 2017
Available online 12 December 2017
1471-0153/

stress disorder (Harned, Korslund, & Linehan, 2014), and eating disorders (Federici & Wisniewski, 2013; Lenz et al., 2014; Lynch et al., 2013; Masson, von Ranson, Wallace, & Safer, 2013).

The strong outcomes of evidence-based therapies in research settings can also be reached in clinical settings if clinicians adhere to manuals and protocols (Pederson Mussell et al., 2000; Wilson, 2005). Unfortunately, there is clear evidence that protocols and manualized approaches are underused by clinicians across a number of therapies for eating disorders (Tobin, Banker, Weisberg, & Bowers, 2007; Wallace & von Ranson, 2011; Waller, Stringer, & Meyer, 2012). This relatively infrequent use of manuals has been linked to a phenomenon conceptualized as 'therapist drift' (Waller, 2009), and occurs when clinicians, consciously or inadvertently, omit or underuse techniques that are an essential part of the therapy. Such techniques can also be underused or inaccurately applied over time, implying a failure to learn the prescribed techniques in the first place and/or a tendency for their use to erode. Clinicians' own cognitive biases, emotions and safety behaviours can interfere with the appropriate delivery of the therapy. However, the underuse or omission of techniques is usually seen by the clinician as being 'protective' with their patients (e.g. not wanting to deliver exposure techniques in order to avoid patient's distress) (Waller, 2009).

In the field of eating disorders, therapist drift has been related to a range of different factors, such as clinicians' anxiety, age and training (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014; Waller et al., 2012). Personality traits such as openness to experience (Peters-Scheffer, Didden, Korzilius, & Sturmey, 2013) have also been related to lower therapy adherence in the treatment of autistic spectrum disorders. Although therapist drift has been clearly demonstrated in CBT and FBT (Kosmerly, Waller, & Lafrance Robinson, 2015; Waller et al., 2012), it is not yet known whether it applies to other evidence-based therapies for eating disorders, and particularly DBT. DiGiorgio, Glass, and Arnkoff (2010) have studied the degree to which clinicians report delivering the core techniques of DBT, although not specifically in the treatment of eating disorders. They demonstrated that DBT clinicians regularly fail to implement core techniques, with differences according to factors such as the client's diagnosis and the intensity of the therapist's DBT training. Therapists showed a greater adherence to protocols when clients had borderline personality disorder as a comorbidity, and if the therapists had a background in applied behavior analysis or radical behavioural approaches, or had received intensive DBT training.

It is not known yet whether these findings of therapist effects would apply to the use of DBT with eating disorders. It is also unclear whether DBT clinicians working with eating disorders form a homogeneous group (all delivering techniques in a similar pattern), or whether they fall into heterogeneous groups (each group delivering a distinct pattern of techniques). Although it is clear that CBT and FBT clinicians each fall into such groups when working with eating disorders (Kosmerly et al., 2015; Waller et al., 2012), it is possible that this finding will not apply to self-identified DBT practitioners in the field of eating disorders (Federici, Wisniewski, & Ben-Porath, 2012; Safer et al., 2009).

Therefore, the primary aim of the present study was to determine the extent to which core DBT techniques are used by DBT clinicians treating patients with eating disorders. It also examined whether therapists fall into distinct groups, based on their usage of different DBT techniques. The final aim was to determine whether clinician's characteristics, specifically intolerance to uncertainty, personality and age, are related to the use of such techniques, given that previous research has shown that these factors might increase the patterns of drift (Meyer et al., 2014; Peters et al., 2013; Waller et al., 2012).

2. Method

2.1. Ethics

The project was approved by the Department of Psychology's Ethics Committee at the University of Sheffield.

2.2. Participants

One hundred and twelve participants who self-identified as DBT clinicians offering DBT to patients with eating disorders initiated the online survey. Of that group, two excluded themselves from the study by not providing informed consent, 14 withdrew at the stage of declaring their age, six due to not working with the appropriate therapy or patient group, and 17 by failing to complete the survey. Therefore, data were available from 73 participants, though the N varies across analyses due to missing data. No compensation was offered to the clinicians for their participation in the study.

The final sample's mean age was 42.2 years (SD = 10.95; range = 26–66). Eighty-nine percent of the participants were female. The majority of the participants were psychologists (56.2%) or social workers (20.5%), while the remaining 23.3% consisted of professionals from other disciplines (e.g., counseling, psychiatry). Their mean duration of experience treating eating disorders was 9.92 years (SD = 6.89; range = 1–26).

2.3. Measures and procedure

Clinicians were approached via an online listserv for clinicians working with eating disorders. This listserv is hosted by the international Academy for Eating Disorders, which represents a diverse range of clinicians working with eating disorders across the lifespan. Given this methodology, it is not possible to provide an accurate response rate for the study. Potential participants were provided with an outline of the study, as an investigation of the patterns of technique use in DBT for eating disorders. If they decided to take part, they could click on a hyperlink, to take them to the consent form and the full survey (using the Qualtrics platform). Following the provision of consent and demographic details, the participants answered questions regarding their use of specific DBT techniques. They then completed brief measures of personality and anxiety.

2.3.1. Use of DBT techniques

The clinicians provided details of their use of a range of DBT techniques when treating eating disorders, taken from a DBT manual for eating disorders (Federici et al., 2012; Safer et al., 2009). These are detailed in Table 1 and in the Results. They include general DBT methods, similar to the techniques assessed by DiGiorgio et al. (2010), that are applicable across disorders (e.g., validation, behavior chain analysis), as well as eating-disorder-specific techniques (e.g., weighing the patient). Each was rated by the clinician regarding how often they used it with their patients with eating disorders ('1–10% of the time' to '90–100% of the time'). This approach is similar to that utilized in previous therapist drift studies (DiGiorgio et al., 2010; Kosmerly et al., 2015; Waller et al., 2012), though it lacks the potential validity of observational methods.

2.3.2. Ten-Item Personality Inventory (TIPI)

The TIPI (Gosling, Rentfrow, & Swann, 2003) is a brief personality test that measures the 'big five' personality dimensions (extraversion, agreeableness, conscientiousness, emotional stability, and openness to experience). Participants indicated their level of agreement with a series of short self-descriptions. The scale is rated on a seven-point scale, ranging from strong disagreement (1) to strong agreement (7). It has acceptable convergent validity (mean $r = 0.77$) with the NEO Personality Inventory (Costa & McCrae, 1992), and acceptable test-retest validity (mean $r = 0.72$).

2.3.3. Intolerance of Uncertainty Scale — Short Version (IUS-12)

The IUS-12 (Carleton, Norton, & Asmundson, 2007) measures the individual's response to uncertain situations. Responses are given on a